inflation for the hospital industry as described in Appendix C. This adjustment is made to place costs reported on a common year-end.

b. This adjusted cost will be divided by the actual Medicaid inpatient days.

c. The payroll expense and employee benefits portion of the industry trend factor as described in Appendix C will be applied to this per diem amount to adjust for the number of months between the mid-point of the calendar year and the

mid-point of the reimbursement period.

d. This adjusted per diem shall be called the Medicaid Prospective Educational Cost Component.

5. Medicaid Prospective Operating Cost Component

a. Total operating costs apportioned to the Medicaid Program will be adjusted for the number of months between the mid-point of the hospital's reporting year and the mid-point of the calendar year most recently ended by the latest actual rate of inflation for the hospital industry as described in Appendix C. This adjustment is made to place all costs reported on a common year-end. This adjusted cost will be separated into labor and non-labor categories based on the percentage of payroll expense and employee benefits to the total market basket as specified in Appendix C.

b. The labor costs and non-labor costs applicable to the Medicaid Program will be divided by the actual Medicaid inpatient days.

c. The labor cost per diem shall be adjusted by a wage index derived from wage index values published in the Federal Register and standardized against Mississippi specific wages.

d. The adjusted labor cost per diem plus the non-labor cost per diem shall be arrayed from highest

to lowest by class of facility. The designated percentile will be selected as the maximum operating cost component.

e. The lesser of actual cost in d. above or the maximum operating cost component will be separated into labor and non-labor categories.

f. The corresponding labor cost per diem wage index adjustment will be made to the lower of the actual adjusted labor cost per diem in d. above, or the ratio of the actual adjusted labor cost per diem to the total per diem in d. times the maximum operating cost component.

g. An industry trend factor as described in Appendix C of this plan will be applied to the sum of the labor per diem in f. above and the non-labor per diem in e. above for the number of months between the mid-point of the most recent calendar year ended and the mid-point of the reimbursement period. The labor portion of the trend factor is set at zero (0) for the period referenced in Appendix C.

h. In accordance with Section III G., an amount will be added (or deducted) for the operating cost applicable to the Medicaid Program for new (or deleted) services or equipment which requires CON approval.

i. The sum of g. and h. is to be called the Medicaid Prospective Operating Cost Component.

E. Setting the Individual Hospital Rates

The individual hopsital rate will be the sum of the Medicaid Prospective

Capital Cost Component, the Medicaid Prospective Educational Cost Component, and the Medicaid Prospective Operating Cost Component. Amounts allowed by appeals or adjustments will be added to or subtracted from this total. This rate shall be referred to as the medicaid Prospective Rate.

VI. Plan Implementation

A. Payments under this plan will be effective for services rendered July 1, 1981 and thereafter.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on the rate methodology before it is implemented. This will be accomplished by publishing in newspapers of widest circulation in each city in Mississippi with a population of 50,000 or more prior to implementing the rate methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of the prospective rate for their hospital.

C. The Division of Medicaid shall maintain any comments received on the plan, subsequent changes to the plan, or rates for a period of five (5) years from the date of receipt.

VII. Application of Sanctions

A. Sanctions may be imposed by the Division of Medicaid against a provider for any one of the following reasons:

1. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, any records of services provided to Medicaid recipients and records of payment made therefor.

2. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the Mississippi Medicaid Commission, the Mississippi Health Care Commission or the Mississippi Foundation for Medical Care.
3. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid Claim form.
4. Documented practice of charging recipients for services over and above that paid by the Commission.
5. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Director of the Health Care Commission, PSRO, or MMC.
6. Failure to meet standards required by State or Federal law for participation.
7. Submission of a false or fraudulent application for provider status.
8. Failure to keep and maintain auditable records as prescribed by the Commission.
9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.
10. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid Program.
11. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.
12. Presenting, or causing to be presented, for payment any false or fraudulent claims for services or merchandise.

13. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the Commission or usual and customary charges as allowed under Commission regulations).
14. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.
15. Exclusion from Medicare because of fraudulent or abusive practices.
16. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

B. The following sanctions may be invoked against providers based on the grounds specified hereinabove:

1. Suspension, reduction, or withholding of payments to a provider;
2. Suspension of participation in the Medicaid Program and/or
3. Disqualification from participation in the Medicaid Program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients or their families.

C. Within thirty (30) days after notice from the Director of the Commission of the intent to sanction, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forthwith particularly the facts which the provider contends places him in compliance with the Commission's regulations or his defenses thereto.

Suspension or withholding of payments may continue until such time as a final determination is made regarding the appropriateness of the claims or amounts in question.

Rec'd _____ HCO-11 # 81-1 Dated _____
Approved 5/13/81 Date eff 7/1/81
Obsoleted by _____ Dated _____

Unless a timely and proper request for a hearing is received by the Commission from the provider, the findings of the Commission shall be considered a final and binding administrative determination.

The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the Mississippi Medicaid Commission.

VIII. Payment Assurance

The State will pay each hospital, which furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the Mississippi Title XIX Inpatient Hospital Reimbursement Plan.

In all circumstances where third party payment is involved, Medicaid will be the payor of last resort. Procedures for remitting third party payments are provided in the Mississippi Medical Assistance Act Hospital Manual.

IX. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of hospitals in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public.

X. Payment In Full

Participation in the program shall be limited to hospitals who accept, as payment in full for services rendered to Medicaid recipients, the amount paid in accordance with this State Plan.

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5/13/81 7/1/81

XI. Plan Evaluation

Documentation will be maintained to effectively monitor and evaluate experience during administration of the plan.

Rec'd _____ PCO-11 # 81-1 Dated _____

Approved 5/13/81 Date 7/1/81

_____ Date _____

Transmittal #81-1

APPENDIX A

Rate Setting Example

The following example shows the step by step process which shall be used to set the Medicaid Prospective Rate for each hospital for the reimbursement period beginning October 1, 19x3. The cost reports for the periods ended in the prior calendar year will be used to set the per diem rate.

Hospital A (60 Bed, Rural Facility)

Y/E September 30, 19x2
Information contained in Cost Report:

Total available days	21,900
Total inpatient days	15,330
Medicaid inpatient days	2,000
Total costs allocated to Medicaid Program	$1,000,000
Total capital costs	$683,000
Total education costs	$100,000

It is assumed for this example that the above data has already been reviewed and adjusted to reflect results of desk reviews, etc.

1. Total cost allocated to the Medicaid Program is to be separated into capital costs, education costs, and operating costs.

   Capital costs allocated to the Medicaid Program: (Based on the ratio of Medicaid inpatient days to total inpatient days) 2,000/15,330 x $683,000 = $89,106. Education costs allocated to the Medicaid Program: 2,000/15,330 x $100,000 - $13,046. Operating cost allocated to the Medicaid Program: $1,000,000 - (89,106 + 13,046) = $897,848.

2. Capital Cost Component

   a. Divide capital cost allocated to Medicaid by the Medicaid inpatient days

	$89,106
	÷
	2,000
	$44.55

3. Educational Cost Component

a. Multiply educational cost allocated to the Medicaid Program by the inflation factor for the number of months between the mid-point of the hospital s reporting year (March 31) and the mid-point of the most recent calendar year (June 30). 3/12 x inflation factor (as determined in Appendix C--for this example 10% is used) $13,046 x 1.025 = $13,372

b. Divide by Medicaid inpatient days ÷ 2,000 = $6.69

c. Apply the trend factor as determined in Appendix C (for this example, 12% is used) for the number of months between the mid-point of the calendar year and the mid-point of the reimbursement period. (June 30, 19x1 and March 31, 19x3) 21/12 x trend factor x1.21

Medicaid Prospective Educational Cost Component $8.09

4. Operating Cost Component

Operating cost allocated to the Medicaid Program $897,848

a. Inflation factor applied for the number of months between the mid-point of the hospital s reporting year and the midpoint of the most recent calendar year 3/12 x inflation factor(10% used for this example) x 1.025 = $920,294

b. Separate this cost into labor and non-labor categories. (A factor based on DOM study as described in the plan will be used. For this example, 65% is used.) x 65%

Labor category $598,191

Non-labor category (balance) $322,103

c. Divide by Medicaid inpatient days ÷ 2,000 ÷2,000 = $299.10 $161.05